Women's Health Screening and Referral Program - Care Questionnaire

The Rhode Island Department of Health would like you to fill out this form while you wait. Your answers will help you and your provider identify services you may need and will help us plan new programs for women. Your answers will be confidential. If you have any concerns, please feel free to discuss it with your provider or call the Family Health Information Line at 1-800-942-7434.

Today's date: ____/____/_____ Date of birth: ____/____/_____

FOR OFFICE USE ONLY

Patient Number: _____ Service Site Number: _____

Positive Pregnancy Test ❑
- ❑ Prenatal Care
- ❑ Home Visiting Program
- ❑ Options Counseling
- ❑ Adolescent Self-Sufficiency Program
- ❑ Rite Care

Negative Pregnancy Test ❑
- ❑ Family Planning
- ❑ Teen Prevention Program
- ❑ Preconception Counseling
- ❑ Other
- ❑ No Referral Available

1.	Are you trying to get pregnant?	❑ Yes ❑ No	
2.	Are you and your partner using birth control now?	❑ Yes ❑ No	
3.	What will you do if you are pregnant? ❑ Keep the baby and raise a family with the father ❑ Keep the baby as a single mother ❑ Place the baby for adoption ❑ Other ❑ Don't know		
4.	Do you have health insurance?	❑ Yes ❑ No	
5.	If you are pregnant, do you have someone to help you?	❑ Yes ❑ No	❑ Home Visiting Program (+) ❑ Other (+/-) ❑ No Referral (-)
6.	Do you ALWAYS have heat, hot water, electricity, and access to a phone?	❑ Yes ❑ No	❑ Home Visiting Program (+) ❑ Community Action Program (+/-)
7.	Have you skipped meals or eaten less because you do not have enough money for food?	❑ Yes ❑ No	❑ WIC (+) ❑ Community Action Program (+/-) ❑ Local Food Bank (+/-) ❑ Other (+/-)
8.	Do you have any concerns about nutrition or diet?	❑ Yes ❑ No	❑ WIC (+) ❑ Nutrition Education (-) ❑ Other (-) ❑ No Referral (-) Available
9.	Have you visited a doctor in the past year?	❑ Yes ❑ No	❑ Early Prenatal Care (+) ❑ Medical Provider (-)
10.	Do you have any medical or health problems?	❑ Yes ❑ No	❑ Early Prenatal Care (+) ❑ Medical Provider (-)
11.	Do you take a multi-vitamin with folic acid every day?	❑ Yes ❑ No	❑ Multivitamin (+/-) ❑ Folic Acid Education (+/-)
12.	Do you have problems getting to the doctor because of transportation, child care, or other reasons?	❑ Yes ❑ No	❑ Home Visiting Program (+) ❑ Other (-) ❑ No Referral (-) Available
13.	Do you smoke? If no, do you spend time with other smokers?	❑ Yes ❑ No ❑ Yes ❑ No	❑ Tobacco Cessation Program (+/-) ❑ Tobacco Cessation Education (+/-) ❑ No Referral (-) Available
14.	Do you drink beer, wine or hard liquor or use marijuana, cocaine, heroin, or other drugs?	❑ Yes ❑ No	❑ Substance Abuse Education (+/-) ❑ Substance Abuse Assessment (+/-) ❑ No Referral (-) Available
15.	Do you use condoms every time you and your partner(s) have sexual intercourse?	❑ Yes ❑ No	❑ STD/HIV Education (+/-) ❑ HIV/STD Counseling/Testing (+/-)
16.	Have you or your partner(s) had Hepatitis, a **positive** HIV test, or AIDS?	❑ Yes ❑ No	❑ Early Prenatal Care (+) ❑ Medical Provider (-)
17.	At home, do you feel physically or verbally threatened or abused?	❑ Yes ❑ No	❑ Domestic Violence Hotline (+/-) 1-800-494-8100
18.	Do you feel depressed or have other mental health problems?	❑ Yes ❑ No	❑ Mental Health Provider (+/-) ❑ No Referral (-) Available
19.	Did you ever have a serious complication with a previous pregnancy or birth?	❑ Yes ❑ No	❑ Early Prenatal Care (+) ❑ Preconception Counseling (-) ❑ No Referral (-) Available
20.	Did you ever deliver a premature baby, a sick baby or have a baby die?	❑ Yes ❑ No	❑ Early Prenatal Care (+) ❑ Preconception Counseling (-) ❑ No Referral (-) Available
21.	Has anyone in your family or your partner's family had any birth defects, mental retardation or developmental delay?	❑ Yes ❑ No	❑ Genetics Counseling (+/-) ❑ No Referral (-) Available

I give permission to release this information to the community referral agencies indicated above.

Please sign your name (voluntary): _____